PEDIATRIC VISIT 17 TO 20 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? _____
Family health history updated? _____
Reactions to immunizations? Yes / No_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

SUBSTANCE ABUSE ASSESS/SCREENING:

Pos / Neg For: _____ **Counseled?** Yes / No
Referral: Yes / No To:_____

RISK ASSESSMENT: CHOL TB STI/HIV

(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:

Problem identified? No / Yes Counseling provided? No / Yes
Referral? No / Yes To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin
☐	☐	Head/Face
☐	☐	Eyes/Red reflex
☐	☐	Cover test/Eye muscles
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums/Dentition
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Tanner Stage/Pelvic/GU
		Age at menarche _____ LMP_____
☐	☐	Musculoskeletal
☐	☐	Neuro/Reflexes
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:

Typical diet *(specify foods)*:
Symptoms of eating disorder? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Select healthy foods ☐ Use skim milk/and lowfat foods ☐
Avoid fad diets ☐ 2 hrs or less of TV/computer games ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐
Vitamin/mineral supplements, folic acid for females ☐ Eat breakfast ☐

DEVELOPMENTAL SURVEILLANCE:

Name of School:
Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Love life ☐ Peer groups pressures ☐ Mood swings ☐
Social misconduct resulting from family dysfunctions ☐
Establishing own values ☐ Future plans ☐ Stay in school ☐

Parenting: Support ☐ Prepare for independence ☐

Health: Dental care ☐ Fluoride ☐ Personal hygiene ☐ Smoking ☐
Second hand smoke ☐ Menstruation ☐ Breast/testicular self-exam ☐
Physical activity ☐ Use sunscreen ☐ Tick prevention ☐

Sexuality: Birth control ☐ Sexual Responsibility ☐ STDs ☐

Injury prevention: Seat belt ☐ Bicycle helmets ☐
Protective devices in sports ☐ Smoke detector/escape plan ☐
Firearms (owner risk/safe storage) ☐ Alcohol/drug use ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐ _____
2. PPD if positive risk assessment ☐ _____
3. Testing/counseling if positive cholesterol risk assessment ☐_____
4. Testing if positive STD/HIV risk assessment ☐ _____
5. Dental visit advised ☐ or date of last visit ☐ _____
6. Next preventive appointment at _____
7. Referrals for identified problems: Yes / No *(specify)*

_____
_____
_____
_____
_____
_____

Signatures:_____